INSTITUTIONAL CHANGE AND HIV/AIDS:

A CRISIS OF PUBLIC GOODS

AND COMMON POOL RESOURCES

Charles C. Caskey

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half of the African American men who are infected are men who have sex with other men (Mann, 1992, p. 34).

Infection rates in the U.S. are estimated to be between 40 and 80 thousand a year with over a million carrying the virus. It is expected, however, that deaths may level off at 50,000 a year in United States (Sills, 1994, p. 11). For those of us who lived through the Vietnam War period, the deaths of young persons each year from AIDS nearly equals the death of young Americans in Vietnam over a decade. One might argue that the death rates from cancer and heart disease are higher, but these predominately strike toward the end of the human life span.

What is more important for the human family is that AIDS is global. There are very few places left on earth where there have not been large increases in human movement creating not only economic and environmental interdependence, but also an interdependence of public health. Consequently, efforts to eradicate diseases like small pox and polio have required global vaccination efforts in order to attain a public good.

In order to achieve or maintain a public good, a combination of incentives and sanction are usually required. For example, in the United States, children registering for public school must have the proper immunizations. In turn, immunizations are made available either free or at low cost. Advertizing the rules, making access to vaccinations available, and monitoring of parental compliance are the responsibility of local health departments. In poor countries, many children go unvaccinated, however, and there are even occasional outbreaks of measles and other infectious diseases in the United States because children or adults have not been vaccinated.

Unlike these highly contagious diseases, many people believe that HIV/AIDS is not a threat to themselves or their community, or their nation. Even when public health is seen as a public good, it is usually left up to government and local health officials to "mind the commons" and enact legislation with selective incentives or threats like quarantine to keep individuals or groups who are perceived to be a danger to public health from shirking. As a result, citizen collective action to protect public health common pool resources (CPRs) such as local blood supplies are often viewed as unnecessary and difficult to mobilize. For example, high information and other transaction costs between 1982 and 1985 in the United States, enabled the blood bank industry to keep the public uninformed about the threat of HIV to the blood supply until law suits were filed and the first out-of-court settlement with the family of a transfusion victim was made by Irwin Memorial Blood Bank in San Francisco (Shilts, 1987, p. 599).

William Haseltine (1992:IV), chief of human retrovirology at Dana-Faber Cancer Institute at Harvard University, has warned that "the epidemic makes it clear that we are our brother's keeper." Unlike droughts, famines, civil wars and ethnic conflicts, the disaster of HIV/AIDS touches the whole human family.

In one sense, prevention seems like a simple task. No vaccine is actually needed. As long as the virus cannot penetrate the blood supply of an individual or community, there is no risk of HIV/AIDS. Yet because many individuals will not modify their behavior to reduce this risk, blood banks have set up elaborate rules regarding who can and cannot be a donor. These rules are used in a screening process which includes testing blood for HIV, record keeping, and monitoring procedures to reduce the risk of HIV in a CPR known as a community or regional blood supply.

Testing and monitoring of blood CPRs of families and community groups are not generally available, although there is mandatory screening in the military and by some firms. In the blood supply of families and social groups, where entry and exit may be anonymous, spontaneous, and under the influence of mood altering substances; dishonest, or just uninformed, actions may result in HIV transmission during sexual contact, shooting drugs, or giving birth to a child. Information costs are usually very high about individual risk, and reliable monitoring is almost impossible. Whereas in the a theoretical market, actors may simply need to change the date of market day, or attract other actors to participate. Changing the "market" of sexual encounters or needle exchanges, however, present formidable obstacles to social scientists.

Some of these barriers are formidable, but others are not. For instance, adolescents and adults are demonstrating rather proficient knowledge regarding HIV transmission. However, information about safer sex or the effectiveness of bleach on cleaning needles does one little benefit in a shooting gallery with only dirty needles and no bleach, or in a sexual encounter where one's partner might question the other's commitment or HIV status by even mentioning prevention. The costs can be very high for some married or unmarried women, because they must consider the risks of physical danger if a male partner becomes angry or threatened by safer sex suggestions. In countless action arenas involving sex and/or drugs, the social capital is often not available to produce outcomes that have a high probability of being optimal, especially for women and the children they may conceive.

ACTION SITUATIONS, ACTORS, AND RULES

If we consider HIV infection is most associated with private acts that have public consequences, perhaps it might be helpful to consider another private act which has harmful personal and societal effects in the action arena where it takes place. One might say that smoking in private potentially harms only the person involved, unless that person is a pregnant woman. While one may smoke totally in private, there are social costs to smoking. For example, a smoking habit may result in a smoker's children going hungry because a significant portion of the family income goes toward the purchase of cigarettes. It is also

statistically likely that the person's health care costs will be higher and productivity and their life-span decreased. As a result, many insurance companies now charge higher premiums to those who choose to smoke. Some of these transaction costs, however, will be born by the community as well as the individual's family and friends. Since most smokers enjoy smoking in the company of others; family, friends, and persons using public accommodations where smoking is permitted pay direct and indirect costs to their health as well.

Many smokers argue that they should have a right to smoke. They may say that those who argue for a smoke free environment in the workplace or in public facilities are infringing on their rights as individuals. Public health officials, however, have now warned of the hazards of second-hand smoke. There is also credible evidence that parents who smoke harm the health of their children, both born and unborn.

The public good of a healthy population and reduced health care costs demand that efforts be made to reduce smoking and the risks to those who may suffer from its effects. Air, however, is one of those common pool resources that is difficult to regulate, even in a public facility. Restaurants and bars claim that they cannot afford to lose their smoking customers and politicians, the support of the tobacco industry and their cadre of loyal, smoking voters.

As difficult as it may be to regulate tobacco in the commons (air), it is even more difficult to reduce the effects of HIV infection which is for the most part also the result of private choices. HIV, however, does not come in visible package that can be purchased and regulated like a tobacco product. As with tobacco related illness, it remains invisible until opportunistic diseases invade the human body. Unlike tobacco smoke whose toxins are released in the air as well as the body, the HIV virus is blood borne and most commonly enters the blood stream through limited means such as transmission through "dirty" needles used to shoot illegal drugs, intimate relationships both heterosexual and homosexual, and in childbearing. As in smoking, almost all acts related to the spread of HIV are private acts, but with even more grave social consequences.

As Ronald Bayer writes in Private Acts, Social Consequences:

> Our collective fate is utterly dependent upon private choices, choices that will be made in the most intimate of settings beyond the observation of even the most thoroughgoing surveillance. We are ultimately dependent on the emergence of a culture of restraint and responsibility that will shape such choices....Like all grave social challenges, the AIDS epidemic thus imposes the necessity of transcending the self-interested perspective so characteristic of everyday life. It demands the emergence of a sense of communal responsibility, of the recognition of a moral obligation to desist from acts that may place others at risk" (1989, pp. 11-12).

The collective action problem involves enforcement of prevention norms regarding individual risk practices. As Broadhead and Heckathorn state:

> AIDS prevention constitutes a public good because the suffering resulting from HIV infection spills over from all affected individuals to their family members and friends" (Broadhead & Heckathorn, 1994, p. 3).

The larger community is affected as well because of the lost productivity and financial costs of treating AIDS.

INSTITUTIONAL CHANGE: COSTS AND PROPOSALS AT A MACRO LEVEL

In 1977, John Knowles, president of the Rockefeller Foundation in an essay titled "The Responsibility of the Individual" remarks that the social consequences of individual behavior in terms of the cost of medical intervention can no longer be tolerated:

> The costs of individual irresponsibility in health care have now become prohibitive. The choice is individual responsibility or social failure. Responsibility and duty must gain some parity with rights and freedom.
>
> (Bayer, 1989, p. 13)

In outlining government action regarding other threats to public health such as alcohol and tobacco consumption, the government could, if it chose to, radically affect the social context of private behaviors through pricing and taxation and through the regulation and control of the use of these substances in public. The public dimension of the acts that are critical for transmission of HIV, however, are exceedingly limited. The bedroom is not the same as a commercial outlet for the sale of alcohol or tobacco, and decisions of sexual behavior and child bearing are not the equivalent of smoking and drinking. As Bayer so carefully points out, "they touch on intimate decisions that only the most totalitarian society could, without great trepidation, consider the realm of appropriate direct state regulation" (Bayer, 1989, p.13).

The central problem which faces the global family regarding HIV, and which health officials and policy-makers must address, is how to change AIDS related behaviors in action arenas which are for the most part private and unmonitored except by the individual actors. In the area of public health policy, liberty and the welfare of the community are always in a state of tension. With the impact of AIDS on health care system in the United States, which is already in crisis, public health officials in the future may no longer be able to pursue policies most likely to contribute to the emergence of a culture of restraint and responsibility relating to these action situations (Bayer, 1989, p. 19).

In a study done in cooperation with the Hudson Institute, Johnston and Hopkins predict that by the end of the decade, the impact of the HIV epidemic on

the health care system of the United States will resemble the aftermath of a major, protracted war (1990, p. 166). Johnston and Hopkins argue that the nation's health efforts have been built around to strategies which are unequal to the extraordinary challenge of HIV. The primary strategy is medical research, however, a vaccine is still at least five or ten years away. The evidence of education campaigns indicates that most people in the United States have the cognitive messages to change risky behavior, but much smaller numbers actually have. Johnston and Hopkins forcefully argue further that a bargain must be struck in the market place between those who have HIV and those who do not: "In return for cooperation in helping to halt the spread of the disease, society owes HIV carriers protection of their civil, employment, and other rights, including access to affordable medical care" (Johnston and Hopkins, 1990, p. 17).

In order to establish boundaries in which this bargaining can take place, however, there must be routine, national, voluntary screening of every adult for HIV. Second, those infected must be discouraged from having sex or share needles with anyone, and those who are HIV free must be discouraged from having sex or sharing needs with anyone whose HIV status is unknown (1990, p. 17).

While these are relatively clear rules, they rely on voluntary testing, the incentive of guaranteed free health care for those who test positive and legal penalties for those who, either knowingly or unknowingly through negligence in not being tested, infect another individual. Johnston and Hopkins are not unaware of the huge transaction costs necessary to implement the kind of program they advocate. Information costs will be high and many will choose not to be socially responsible. Virtually every side of the political spectrum will object to some portion of the program; either the large-scale testing, or the free medical care and aggressive defense of civil rights as an enticement for testing. With $650 million for the testing alone, the costs of the program will be very large (Johnston and Hopkins, 1990, p. 19).

The following, according to the authors of the plan, is the alternative:

> If such a strategy is not pursued, however, the nation stands little chance of arresting the spread of HIV during the balance of the century. Inexorably, it will move through society, destroying the lives of more and more Americans, concentrating its destruction among the black poor, but also endangering many sexually active young people of all socioeconomic strata (1990, pp. 21-22).

INSTITUTIONAL CHANGE: THEORY AND COLLECTIVE ACTION AT A MICRO LEVEL

While it is important for there to be collective action on a large scale, the work of Mancur Olson reveals the limits of group action. Mancur Olson, writing in The Logic of Collective Action, challenged the optimism of group theory which argued that individuals with common interests would act voluntarily

to try to further those interests (Bentley 1949; Truman 1958). He said that "unless the number of individuals is quite small, or unless there is coercion or some other special device to make individuals act in the common interest, *rational, self-interested individuals will not act to achieve their common or group interests*" (Olson, 1965, p. 2) Voluntary provision for collective benefits depends not on the number of actors involved, but how visible each person's actions are, according to Olson.

The problem with public health as a public good in the case of HIV is that high-risk behavior may not be perceived as high risk for a number of reasons: one may not know one's own HIV status or that of one's sexual partner because of high information costs even for those who are educated about HIV, or because the pleasures of the moment override rational intention as the temptation to free-ride dominates the decision process in the bedroom or the shooting gallery.

As noted in Olson's analysis, group size is very important. In a small group, each person receives a return from contributions to the collective good and free-riding is somewhat visible. In larger groups, each person's contribution is relatively small and the individual is less likely to be aware of any common interest. Thus, the desire to participate in a collective action is likely to be low and free-riding may remain invisible from the group at large.

As Elinor Ostrom states in Governing the Commons (1990): "Individuals attribute less value to benefits that they expect to receive in the distant future, and more value to those expected in the immediate future." Sexual pleasure and drug-induced highs are often perceived by individuals as much more important short range goals than HIV prevention; which, if thought about at all, is likely to be perceived as a low risk threat caused by having sex or sharing a needle with someone whose HIV status probably unknown but "looks healthy."

For most individuals, even those in "so called" high risk groups, the danger of contracting HIV may be perceived as no higher than being struck by a car while jay-walking, as opposed to following a norm or law which says to cross at an intersection. For those who inject drugs, dangers of HIV can be minor compared to the dangers from an overdose.

While HIV can be viewed as a private health problem of individuals, the HIV/AIDS epidemic and HIV prevention are also collective action problems which result from the conflict between individuals behavior and the common interests of the communities to whom they belong. The immediate communities are partners in the activities and families and friends. As is often the case, the common interests of these communities go unstated or unacknowledged by the individual actors.

In a discussion of the limitations of micro-level reasoning, Robert Bates refers to the work of Scott in The Moral Economy of the Peasant (1976) who in his analysis of choice theory accounted for collective behavior by showing that it was consistent with the rational behavior of individuals, given their

preferences. Popkin pointed out, however, that between individual preferences and social outcomes is the problem of aggregation. Social outcomes are not necessarily related to individual preferences. As Bates forcefully argues:

> For a variety of powerful and fundamental reasons, rational individuals can make decisions that result in socially irrational customs (the classic analysis is Arrow 1968; see also Hardin and Barry 1982). As argued by Popkin, this problem arises with particular clarity over the provision of public goods, ...(Bates, 1990, p. 37)....With respect to collective goods, it is therefore inappropriate to reason from the level of individual values to the level of collective outcomes (Bates, 1990, p. 38).

As Popkin and other point out attention must be paid to the point where individual preferences gain collective expression, that is in the process of aggregation (Bates, 1990, p.38). Bates argues that, as a theory of aggregation, the theory of collective action (Olson, 1965, Hardin 1982) provides for political economy because it "examines the behavior of individuals in markets in which actors possess incentives to engage in strategic behavior" (Bates, 1990, p. 41).

Bates describes "selective incentives" as the "costs or benefits that are conferred when a desired act is performed. As he describes it, collective action works when selective incentives are used. His argument is presented as follows:

> Armed with selective incentives, political entrepreneurs can reward those who contribute to the collective good and penalize those who do not; political contributors then no longer find it in their interests to free ride
>
> (Bates, 1990, p. 43).

However, as with the Johnston and Hopkins plan for selective incentives, "constitutional structure thus determines which interests can shape collective outcomes by engaging in collective action" (Bates, p.44). Bates closes his comments about choice theoretic reasoning by saying people's beliefs and values also matter, and they systematically shape collective outcomes. Thus the shape of HIV AIDS collective choice and outcomes will be different for different groups in our extended global family. Choice theory can offer the tools as Bates and others recognize to link values and structures to their social consequences. This is vital in the struggle against HIV/AIDS whose solutions are so tied to values and institutional structure (Bates, 1990, p. 44).

The work of Robert Putnam, as outlined in Making Democracy Work: Civic Traditions in Modern Italy (1993), can give us additional clues to how collective action situations should be structured. His analysis of patron-client relations might be useful as we consider traditional medical and public health models:

> Patron-client relations,..., involve interpersonal exchange

> and reciprocal obligations, but the exchange is vertical and the obligations asymmetric....Two clients of the same patron, lacking direct ties, hold nothing hostage to one another. They have nothing to stake against mutual defection and nothing to fear from mutual alienation. They have no occasion to develop a norm of generalized reciprocity and no history of mutual collaboration to draw on. In the vertical patron-client relationship, characterized by dependence instead of mutuality, opportunism is more likely on the part of both patron (exploitation) and client (shirking)(Putnam, p. 175).

The horizontal relationships among the gay community and to lesser extent among the IV drug users early in the AIDS crisis dramatically slowed the rates of HIV infection before government programs were substantially underway (Shilts, 1987, Des Jarlais et al. 1985). As Panem describes in The AIDS Bureaucracy, , we can see the importance of social capital and networking by the gay community in San Francisco which was both active and prominent, and that differed markedly from the community in New York which was made up of isolated constituencies with no community standing or clout. This horizontal networking was largely responsible for the fact that San Francisco had the first county task force and the first hospital with a unit devoted to AIDS. San Francisco began early with public health programs and distributing AIDS educational materials. New York did not (Panem, 1988, p. 16).

In fact the "patron" (researchers, clinicians, and public health officials) view of "clients"(intravenous drug users) ,(IDUs), was that they did not care about their health and that they were not behavioral change oriented (Friedman et al. 1987). Broadhead and Heckathorn state that IDUs do have real concerns about their health. Some had even begun taking steps to reduce needle sharing on their own in reaction to reports about AIDS. They note that by 1984 the demand for clean needles in New York City resulted in the creation of a new market ready to be exploited by drug dealers who began repackaging and selling used needles as new ones (Broadhead, 1994, pp. 5-6).

Perrow and Guillen, in a three year project funded by the American Foundation for AIDS Research (AMFAR) and published in 1990, note that the United States was the only major western nation not to have a national education program as late as 1987. Risk reduction guidelines published in 1983 were limited to avoiding sexual contact with anyone with AIDS and that high-risk groups should be aware that multiple sexual partners increase the probability of developing AIDS. Conservatives in Congress successfully blocked the use of Center for Disease Control funds for education at the same time a conservative government in Great Britain launched a "massive, sexually explicit education campaign" (Perrow and Guillen, 1990, p. 18).

New York City, at the epicenter of the AIDS epidemic in the United States, can be used to illustrate the problems faced by minority populations. By May of 1983, New York policymakers knew that AIDS was reaching epidemic proportions in the city with the number of cases doubling every six months. It was not until 1988, however, that much attention was paid to one of the hardest hit populations, IV drug users. By this time, approximately 50% of the population of drug users or 100,000 people had become infected (1990, pp. 19, 96).

As we look at the collective action of this community, we see that in the larger community they had become an invisible part of the epidemic. Minority politicians, as well as the moral majority and the Catholic Church, had defined AIDS as a gay-related problem only. As groups competed for attention at the local, state, and national level, white, gay males were given the "green light" to run whatever educational programs would take place, while the IV drug users and the gay and bisexual men in the minority community were ignored. By the end of the decade, other minority populations were being infected in increasingly higher numbers. These were black and Hispanic women and children, for the most part the spouses and children of infected males.

As these groups were largely an invisible part of the epidemic at the state and local levels of government, they were also neglected by the minority communities from which them came. While homosexual behavior, rather than homosexual identity, is common among black and hispanic communities; culturally, condoms are associated with white homosexuals. In addition, the church is still the primary support organization for both communities. Within both the black protestant community and the Hispanic Catholic community, the predominate view of church leaders is that homosexual behavior and drug abuse are sins. Thus educating a population at risk about condom use and clean needles would be seen as sin. Finally, AIDS is just one more burden for these communities on top of many others (drugs, poor schools, poor health services, unemployment, low skills, lack of decent housing, rising TB and syphilis rates, and above all, rampant crime). Sympathy within both communities for the victims of drugs and AIDS is in short supply, according to the study of Perrow and Guillen (p. 100). Male dominated "macho" societies make it more difficult to discuss sexual orientation and condom use to protect female partners of bisexuals and IV drug users (Perrow and Guillen, 1990, p. 193).

It is important to recognize these institutional constraints that add to the resistance to change in communities most affected by the epidemic as we search for solutions which will meet the needs of the communities most affected and those at risk.

In AIDS in the Industrialized Democracies (1992), Bayer and Kirp identify two types of policies used to combat AIDS at the macro level, one is a contain and control strategy and the other is cooperation and inclusion. As the focus in the United States turns from the white, gay community to poor black and

Hispanic communities, they predict that pressure for contain and control strategies will grow (Bayer and Kirp, 1992, 43-44).

Again at the macro level, the final report of the National Commission on AIDS (1993) is severely critical of the silence at too many levels of responsibility from governors, mayors, members of Congress, corporate executives, community and religious leaders, some perhaps taking their cue from previous presidents. Consequently, the scale of the problem is seriously under estimated, and fear, prejudice and misinformation abound. Leaders have both the capacity and the responsibility to coalesce their communities to find solutions (1993, NCA, 1993, p. 13)

The committee also decries the national approach to the issue of substance abuse, which primarily focuses on the criminal justice system to solve this complex societal problem. Substance abuse is often an important factor in action situations that result in AIDS, not just because HIV is transmitted through IV drug use, but because prevention behaviors are less likely to be used during sexual encounters. One of the important recommendations of the commission refers to the legal barriers to the purchase and possession of injection equipment. While not reducing illicit drug injection, these barriers limit the availability of new/clean injection equipment and therefore encourage the sharing of equipment, and thus the increase in HIV transmission. In the United States and in other countries programs that link needle exchange and bleach distribution with drug treatment have been shown to be successful (NCA, 1991 p. 7).

Barriers to treatment are another problem. Discounting the availability of treatment slots, addicts who are homeless and with no support services must present "at least two pieces of identification, a permanent mailing address, be Medicaid eligible, give and pay for a urine test, have an initial first fee for screening for the screening day, go through a series of interviews and processes, and after all this they may be admitted and medicated" (NCA, 1991, p.9).

As we have discussed the moral and social attributes of the communities most at risk for HIV and legal and community rules in use, we must also keep in mind other environmental factors as well. The neighborhoods where the bedrooms and shooting galleries are located, especially non-white, are toxic agents themselves and must be stabilized and provided with an economic base to replace the underground economy which pushes and promotes crack addiction. Poverty and homelessness, lack of medical care and substance abuse, sexuality and HIV are inexorably linked in most of the action arenas where HIV transmission takes places in the U.S. Most of the actors involved are young and members of minority groups (NCA, 1991, 14-15).

AIDS strongly advocates a "harm reduction" approach which makes access to sterile injection equipment available as well as provides for a shift in resources from interdiction and mandatory punishment toward drug treatment (NCA, 1993, p. 10).

A realistic look at the collective action potential of HIV drug users and adolescents has not been examined as extensively as the collective action which certain gay communities took in the mid-eighties. These communities were unorganized, but individuals found that the increasing numbers of deaths among middle-aged gay men were a strong incentive for collective action.

Adolescents, because of their invincablity and the fact that the symptoms of AIDS do not develop for many infected persons for eight to ten years after infection, fail to experience the immediacy of the threat and, therefore, have fewer incentives to change behaviors. This is true for gay youth as well, even those who live in communities like San Francisco where many gay men in the thirties and forties have died. There are now, of course, fewer mentors close enough in age to model appropriate risk reduction behaviors!

Perhaps the greatest barriers to institutional change have to do with the non-identification of individuals, adolescent or adult, with particular groups at risk for HIV, particularly since many of these groups are stigmatized within the broader culture. For collective action to benefit public health in the future, individuals need to be given more support in this identification process.

Without an institutional change at the constitutional level, the program suggested by Johnson and Hopkins (1990, p. 7), which separates the infected from the uninfected may need to be implemented to reduce the numbers of those who are now infected every year. Appropriate incentives for collective action could, however, make more drastic measures unnecessary.

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